TAOP TRICARE Advanced Course 2010

Dental

Dental Objectives

- ADSM Dental Care
  - Overseas
  - Stateside
- ADFM Dental Care
  - Overseas
- Non-Availability & Referral Form (NARF)

Dental

ADSM Dental Care: Overseas

Dental

ADSM Dental Care: Overseas

- Enrolled into TOP Prime:
  - All dental care should be received at the local ODTF
- Enrolled into TGRO:
  - Contact ISOS if not near an ODTF; routine, urgent & emergent
- On leave, TAD/TDY:
  - Urgent/emergent: Contact ISOS for assistance if not near an ODTF
  - Routine: ODTF only

Dental

ADSM Dental Care: Stateside

Dental

ADSM Dental Care: Stateside

- Active Duty Dental Program (ADDP) - Changes the way ADSMs receive dental care outside of DTFs stateside; Administered by UCCI
  - https://secure.addp-ucci.com/ddpddw/home.xhtml
  - 1-866-984-ADDP (2337)
  - Includes American Samoa, Guam & Saipan, US Virgin Islands & Puerto Rico
- Emergent Dental Care:
  - Contact DTF if located within 50 miles of one
  - If not located near a DTF, seek care at any US licensed dental provider (UCCI network provider is preferable)
- Provider can submit a standard American Dental Association claim form to the following address:

UCCI – ADDP Claims

P.O. Box 69429

Harrisburg, PA 17106-9429

Dental

ADSM Dental Care: Stateside

- Urgent and routine dental care should always be sought from a DTF if located within 50 miles
- All ADSMs must receive an Appointment Control Number (ACN) from UCCI before receiving private sector dental care.
- DTF referral to civilian network dentist;
  - DTF will provide:
    - *Informational Flyer*
    - *Referral Request Confirmation sheet*
      - Contains ACN and services/procedures to be rendered
- Remote Locations (More than 50 miles from a DTF):
  - Complete online request form to receive ACN
    - *Must choose who will schedule appointment. If ADSM schedules own appointment, he/she must contact UCCI to give provider information.*
  - Can contact UCCI by phone to request an ACN; 1-866-984-ADDP (2337)
  - ACN will be provided within 2 business days

Dental

ADFM Dental Care: Overseas

Dental

ADFM Dental Care: Overseas

- Only have dental benefits if enrolled into TDP w/UCCI
- If possible, seek care from an ODTF
- Two options for civilian dental care:
  - TRICARE OCONUS Preferred Dentists (TOPD);
    - *Search: http://www.tricaredentalprogram.com/tdptws/enrollees/hnp/hnp_search.jsp*
    - *Will only be required to pay applicable cost-shares up front*
    - *Provider will submit claim to UCCI*
  - Non-preferred dentists;
    - *Can receive care from any licensed host nation dental provider*
    - *Pay in full upfront and submit own claim for reimbursement*

Dental
ADFM Dental Care: Overseas

- Submitting Claims to UCCI – Required items:
  - OCONUS TDP claim form
    - *http://www.tricaredentalprogram.com/tdpforms/5678-oconus.pdf*
  - Dentist's bill or statement of charges
  - Receipts
- Claims address (Also on OCONUS TDP claims form)

UCCI - TDP OCONUS Dental Unit

P.O. Box 69418

Harrisburg, PA 17106-9418 USA

Dental

ADFM Dental Care: Overseas

DENTIST'S CLAIM FORM

Check One: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

UNITED CONCORDIA
TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418 USA

Form Approved
OMB No. 0720-0035
Expires Jan. 31, 2013

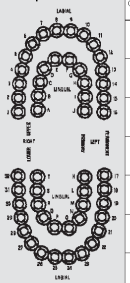
PATIENT SECTION

1. Patient name
2. Relationship to sponsor: self / spouse / child / other
3. Sex: m / f
4. Patient birthdate: mo / day / year
5. If full-time student: school / city
6. Sponsor's name: First / Middle / Last
7. Sponsor's Social Security number (SSN)
8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)
9. Telephone number **(include country, city, and/or area code)**
10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
Signature (patient or parent if minor) / Date
11. Branch of service
12. Group name
TRICARE Dental Program
13. Is patient covered by another dental plan? ☐ yes ☐ no
Dental plan name
Insured name and SSN / Group no.
Name and address of carrier
14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.
Signature (insured person) / Date

DENTIST SECTION

15. Dentist name
16. Office address: Street, city, country, postal mailing code
16a. Billing address: Street, city, country, postal mailing code
17. Dentist phone no. (including country, city, and/or area code)
18. UCCI dentist no.
19. Dentist fax no.
20. Dentist email address
21. Point of contact (POC) name, telephone no., fax no., and email address
22. Is treatment result of occupational illness or injury? No / Yes — If yes, enter brief description and dates
23. Is treatment result of auto accident?
24. Other accident?
25. If prosthesis, is this initial placement? (If no, reason for replacement) 26. Date of prior placement
27. Is treatment for orthodontics? Appliance insertion date / Total length of treatment
(Non-Availability and Referral Form Necessary)
28. Transfer patient? If yes, reband date / If no, starting date of treatment
Was patient rebanded?

Indicate tooth/ teeth no.(s) for which services were provided.



29. Examination and treatment plan—list in order from Tooth No. 1 through Tooth No. 32—Use charting system shown.

TOOTH NO. OR LETTER U.S.	INT'L	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MONTH	DAY	YEAR	PROCEDURE CODE	FEE CHARGED

30. Remarks for unusual services

31. Any person who knowingly files a statement of claim containing any misrepresentation or false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or federal law and may also be subject to civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I hereby certify that the procedures as indicated by date have been completed.

Signature (Dentist) / Date

32. **TOTAL FEE CHARGED**

33. **INDICATE CURRENCY** ☐ USD ☐ LOCAL

AMOUNT PAID

5678 F 02/10 **OCONUS**

Dental

Non-Availability Referral Form (NARF)

Dental NARF

- Required for any orthodontic or implant services that cannot be obtained at an ODTF
  - http://www.tricaredentalprogram.com/tdpforms/NARF_Form2.pdf
- Initial NARF required from ODTF/TAOP Dental Rep for diagnosis & treatment planning appt
  - Can be backdated for past appointment dates
- Submit claim to UCCI for initial appt along w/required
  - Completed OCONUS TDP Claim
  - Copy of Initial NARF from the ODTF/TAO-P Dental Rep.
  - Any receipts showing payment made

Dental NARF

- Diagnosis & treatment plan need to be reviewed by the TAOP dental Rep; the following are required:
  - Radiographs
  - Photographs
  - Cephalometric tracings
  - Completed diagnosis sheet (Request from TAOP Dental Rep)
- If plan is approved, the TAOP Dental Rep. will issue the approval NARF & treatment may be started.
- Once treatment is received, submit claims & required documentation to OCONUS claims department.

Dental NARF

TRICARE Dental Program

Form to be used beginning February 1, 2006
(Form also located at www.TRICAREdentalprogram.com)

NOTE: This form is only necessary for OCONUS **orthodontic and implant** care. In *Non-Remote Countries*, the sponsor/family member must forward this completed form to United Concordia with the completed claim form and the provider's bill for the claim to be processed. In *Remote Countries*, the sponsor or the location Point of Contact (POC) must forward this form to United Concordia along with a completed TDP OCONUS Claim Form and the provider's total bill. Additional information can be found in the TDP Benefit Booklet.

OCONUS NON-AVAILABILITY AND REFERRAL FORM (NARF)

PATIENT INFORMATION

1) PATIENT'S NAME — LAST / FIRST / MI

2) DATE OF BIRTH — MO / DAY / YEAR

3) SEX — M ☐ F ☐

4) RELATIONSHIP TO SPONSOR — SPOUSE ☐ CHILD ☐ OTHER ☐

5) SPONSOR'S NAME — LAST / FIRST / MI

6) SPONSOR'S SOCIAL SECURITY NUMBER

7) PATIENT'S ADDRESS (APO/FPO or Street, City, Country, Postal Mailing Code)

REFERRAL INFORMATION

8) REFERRING OVERSEAS DENTAL TREATMENT FACILITY/TRICARE AREA OFFICE (Name and Location)

9) PRIMARY REASON FOR REFERRAL:

☐ a) Proper facilities or professional capability are temporarily not available at this facility.

☐ b) Proper facilities or professional capability are permanently not available at this facility.

10) REFERRED SERVICE (Description of Service—include CDT code(s) if possible)

Orthodontics: ☐

☐ Diagnostic ☐ Limited CDT Codes:

☐ Extensive ☐ Retainer

Implants: ☐

CDT Codes:

11) REMARKS

12) NAME AND TITLE (Type or Print)

13) APPROVAL SIGNATURE

14) DATE OF ISSUANCE *

* NOTE: FORM VALID FOR 120 DAYS FROM DATE OF ISSUANCE

SPONSOR/FAMILY MEMBER CERTIFICATION

15) SPONSOR/FAMILY MEMBER CERTIFICATION

I have confirmed my enrollment in the TDP. If I am not enrolled, I am responsible for the full cost of any dental care received.

I confirm that, as of the date of this referral, I have not exceeded the appropriate lifetime orthodontic maximum. I understand that, if I have exceeded my maximum ($1,500 for orthodontic services), I am responsible for the full cost of any additional orthodontic services received.

I understand that, if I receive services for dental care not covered under this referral, I am responsible for the full cost of any dental care received outside the scope of this referral.

SIGNATURE (Sponsor/Family Member) _____ DATE

16) I have received confirmation from the sponsor/family member that the above is true and that the sponsor/family member agrees to these certifications as of the date of this referral.

INITIALS (Referring Party) DATE

17) ODTF/TRICARE AREA OFFICE TRACKING NUMBER

The information contained on this form is protected by the Privacy Act of 1974.

The quality of foreign provider care is not controlled by the Government or United Concordia or any of its agents or representatives. The fact that a foreign provider has been determined to provide acceptable dental care in the past does not guarantee acceptable future service. The Government's control over foreign providers is limited to their inclusion in or exclusion from the host nation provider list. Sponsors/family members should forward any complaints or concerns about foreign provider service quality of care to their respective TRICARE Area Office.

Dental
NARF

- TAOP Dental Representative contact Information:

CAPT David Metzler (USN)

Phone: DSN (315) 643-2059 - COMM +81-611-743-2059

Fax: DSN (315) 643-2043 - COMM +81-611-743-2043

Email: david.metzler@med.navy.mil

Dental
Things to Remember

- **Complete info on enrolling/disenrolling, eligibility, out-of-pocket expenses, locating providers, etc. can be found on the TDP website: http://www.tricaredentalprogram.com/tdptws/home.jsp**
- **Complete info on the ADDP can be found here: https://secure.addp-ucci.com/ddpddw/home.xhtml**

Dental Questions